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HEALTHCARE IN CENTRAL ASIA

TECHNICAL DOCUMENT:

Improving the Quality of Reproductive Health Services in Issyk-Kul Oblast, Kyrgyzstan: Report on a Pilot Project

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March 2002
Issyk-Kul Oblast, Kyrgyzstan

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Table of Contents

I. Acronyms and Abbreviations

COCs	Combined oral contraceptives
DMPA	Depotmedroxyprogesterone acetate or Depo Provera (injectable contraceptive)
DPT	Diphtheria, tetanus and pertussis vaccine
FGP	Family Group Practice
FMTC	Family Medicine Training Center
IUD	Intrauterine device
LAM	Lactational amenorrhea method
MOH	Ministry of Health
NGO	Nongovernmental organization
PNC	Prenatal care
QIS	Quality Improvement System
TB	Tuberculosis
USAID	United States Agency for International Development

II. Abstract

Working to improve the quality and efficiency of health services in Central Asia is a critical part of the ZdravPlus project. One important area of health service delivery is reproductive health, and ZdravPlus initiated a pilot Quality Improvement System (QIS) in this area within three FGPs in the Issyk-Kul Oblast of Kyrgyzstan. The system - based on a number of subjective and objective assessment tools, with continual evaluation, feedback, and subsequent action - had very positive results. These results showed both a clear improvement in clinical competence in providing contraceptive and prenatal care, and a significantly better grasp of the importance of issues such as providing promotional materials for clients, improving the physical appearance of the FGP, and improving privacy and confidentiality between client and physician. In addition the QIS empowered FGP staff to feel that they could make significant changes to quality using local resources and initiative.

III. Executive Summary

With ongoing health reforms in Kyrgyzstan introducing new methods of delivering health services, the question of the quality of those health services is critical. Part of ZdravPlus' work in Central Asia is to help improve the quality and efficiency of health services. One important area of health service delivery is reproductive health, and counterparts from Issyk-Kul Oblast were interested in improving service quality in this area. In order to do this at the FGP level, ZdravPlus piloted a Quality Improvement System (QIS) with three FGPs in Issyk-Kul Oblast.

The QIS teams up supervisors (curators) with FGPs. The object of the QIS is for the FGP to improve its own quality using locally available resources, with the supervisor and the QIS effectively acting as catalyst.

Within the QIS the curator responsible visits his or her FGP once every three months, and uses a combination of objective and subjective tools to help assess the quality of the services offered. These are: 1.) An *exit interview* which measures quality objectively from the client's perspective; 2) A *facility walk-through* where the curator uses a checklist based on MOH standards to assess the facility's "readiness" to provide services; 3.) *Observation of the providers* in which the curator observes clinical staff providing contraceptive and prenatal care services to clients and then offers immediate feedback; 4.) A *self-assessment meeting* in which all the staff of a facility meets to identify problems related to quality of care.

Once problems are identified using the four tools, the staff of the FGP works as a team to determine the causes of the problems, to identify priority problems and to develop action plans to address these at the local level. The cycle is then repeated so that continuous measurement and improvement takes place.

Three rounds of the QIS took place in Issyk-Kul Oblast at the three pilot FGPs between February and September 2001. A number of interesting results were identified as a result:

- Clinical competence in providing contraceptive and prenatal care clearly improved.
- Although the availability of contraceptives is limited in Issyk-Kul, the QIS helped to bring the FGPs together to address this issue and led to joint applications to the Oblast Reproductive Health Center to ask for more autonomy over distribution of donor-provided contraceptives for the local FGPA.
- AS a result of the QIS all three FGPs improved reproductive health information available to clients in their newly-arranged waiting rooms.
- Healthcare providers were introduced to the clients' perspective for the first time. Many of the problems clients associated with quality of care were related to FGP appearance as opposed to issues of a clinical nature. FGPs were able to remedy these problems in a number of creative ways
- A first round facility review noted the absence of laboratory facilities at the FGPs, and the FGPs subsequently took it upon themselves to raise funds to equip themselves with laboratory facilities.
- The FGPs took steps to improve the privacy and confidentiality of consultations with doctors after learning through both self-assessment meetings and client interviews that these were problem areas.

Ultimately, the QIS was looked upon as a valuable system by both FGP staff and curators, and one that both parties would continue to use. In fact, a fourth round of the QIS took place in early 2002, which was managed entirely by the FGPs involved.

While the problems faced in this trial period were relatively simple, their resolution significantly improved the management capabilities of the FGPs. Some of the more difficult problems to overcome, such as the shortage of contraceptives, lack of permanent premises and funding shortfalls were beyond the control of the individual clinics to solve. However, it is encouraging that the clinics united to try and solve some of

those problems deemed beyond an individual clinic's capability. Many of the concepts adopted were new concepts in post-Soviet environments, and appear even more impressive as a result.

Interviews conducted with FGP staff and curators following the QIS project helped to identify areas of refinement for future QIS projects. They also brought to light the fact that the QIS increased the FGP staff's motivation, made them feel like part of a team and helped them feel empowered as regards solving their own problems internally.

IV. Introduction

Health reforms in Kyrgyzstan seek to improve the quality and efficiency of health services, with an emphasis on strengthening primary healthcare. In a shift from the Soviet system that centered on highly specialized care provided in highly specialized facilities, newly formed Family Group Practices (FGPs) in Kyrgyzstan bring together internists, gynecologists and pediatricians into primary healthcare practices that provide a range of services in a single facility close to where people live. Other contrasts with the past mean that FGPs now have their own budgets, based on a capitated payment for each person enrolled, and they compete for clients. No longer are they required to follow detailed instructions from central authorities or to formally request every item needed to provide services. They have considerable autonomy in how they manage their facilities and services. However, many challenges remain. The FGPs need to improve the quality of the services they provide, they need to use their newfound autonomy to manage their facilities more effectively, and they need to respond better to clients' needs.

The Central Asia Quality Health Project – known as the ZdravPlus project – funded by the US Agency for International Development (USAID) is working with the governments of five Central Asian countries to improve the quality and efficiency of health services. The project works in selected areas of these countries to support health sector reform as well as technical assistance, training and limited provision of equipment.

Reproductive health is an important priority under the project and counterparts in Issyk-Kul Oblast (province) in Kyrgyzstan were interested in new approaches to improving the quality of reproductive health services. Accordingly, ZdravPlus piloted a Quality Improvement System (QIS) with three FGPs in Issyk-Kul. The system teams FGPs with supervisors and is designed to improve the quality of care as well as to support the vision of an FGP as a client- and market-oriented healthcare provider, with a staff that works as a team to manage services and resources effectively. The pilot also sought to demonstrate the potential of supportive supervision as an alternative to the system inherited from the Soviets that still relies on fines and punishments for adverse health outcomes and for infractions of a web of rules, regulations and administrative requirements.

The [QIS] system teams FGPs with supervisors and is designed to improve the quality of care as well as to support the vision of an FGP as a client- and market-oriented healthcare provider, with a staff that works as a team to manage services and resources effectively.

This report outlines the quality improvement system adopted by the pilot project in Issyk-Kul and discusses the impact of the system on the participating FGPs and their services during the first seven months.

V. The Quality Improvement System (QIS)

The QIS was adapted from a system developed by the Reproductive Health Association of Cambodia, with USAID support. Counterparts in Issyk-Kul liked the Cambodian system because of its ease of use and its successful implementation in Cambodia. Both countries share an Asian culture that hesitates to criticize, as well as having emerged from a communist past and having somewhat similar health systems.

Before the pilot project started, FGP heads were invited to a meeting where the principles of the QIS were explained and they were invited to volunteer their FGP to participate in the pilot. Three FGPs were selected based on their size, client load and the interest of the staff.

One of the challenges in Kyrgyzstan was to identify a cadre of individuals that could serve as supervisors, working with FGPs in ways that would build their skills and empower them to make their own decisions – in sharp contrast to the existing inspectors. In addition, ZdravPlus sought to vest this function in an

institution where it had the potential to be institutionalized. Family medicine trainers and the local Family Medicine Training Center (FMTC) met these criteria and hence the QIS in Issyk-Kul draws on their clinical and interpersonal skills, expanding their role to become "curators"—the local term for supervisors.

In the QIS, a curator visits "her" FGP every three months (a "round") and works with the staff to assess the quality of services, using four different tools:

- The first tool is an *exit interview* that objectively measures quality from the clients' perspective and allows for the results to be quantified. Clients are asked to score providers' actions on a scale of one to five. The questions address clients' opinion of confidentiality, provider-client relations, waiting time, sanitary conditions, etc. They also solicit clients' suggestions. The interviews promote a client orientation among providers. In this pilot, an independent NGO called "Leader" conducted between 75 and 100 interviews per FGP per round and presented the results to the curators and FGPs.

- The second tool is a *facility walk-through*, where the curator goes through the facility with a checklist based on Ministry of Health (MOH) standards. The checklist provides a guide for the evaluation of the "readiness" of the facility to provide services. This tool combines a client perspective with a more clinical approach. The checklist used in the Issyk-Kul pilot addresses clinical issues – such as equipment, instruments, drugs and supplies, record keeping and sanitation – along with more client- and community-oriented concerns, such as the availability of information for clients, client comfort, confidentiality, fundraising plans and community relations.

- The third tool is the *observation of providers*, in which the curator observes clinical staff providing services to clients. After observing a clinician providing services, the curator offers him/her immediate feedback to increase his/her technical competence – *not* to criticize or punish. In the pilot project, curators observed contraceptive and prenatal care services. There is a separate checklist for each service – one for prenatal care and one for each family planning method – based on Kyrgyz guidelines for these services. Each item on the checklist is scored: two points are awarded if it is performed correctly and completely; one point if it is performed, but not completely or correctly; and zero points if it is not performed at all. Thus, each observation yields a percentage score for that skill for that provider. Average scores can be calculated for all the providers in an FGP as well as across FGPs.

- The last tool is a *self-assessment meeting*, in which the entire staff of the facility meets to identify problems in the quality of care. To facilitate discussion, the curators in Issyk-Kul developed a list of questions to trigger discussion when staff members hesitate to speak out about issues that concern them. In the self-assessment meeting, FGP staff also discuss the results of the client interviews, observation of services and the facility walk-through.

Together, these four tools provide both objective and subjective measures of the quality of services provided and offer clients and providers structured ways to express their ideas and opinions. See Table 1.

Table 1. Assessing Quality from Clients' and Providers' Perspectives

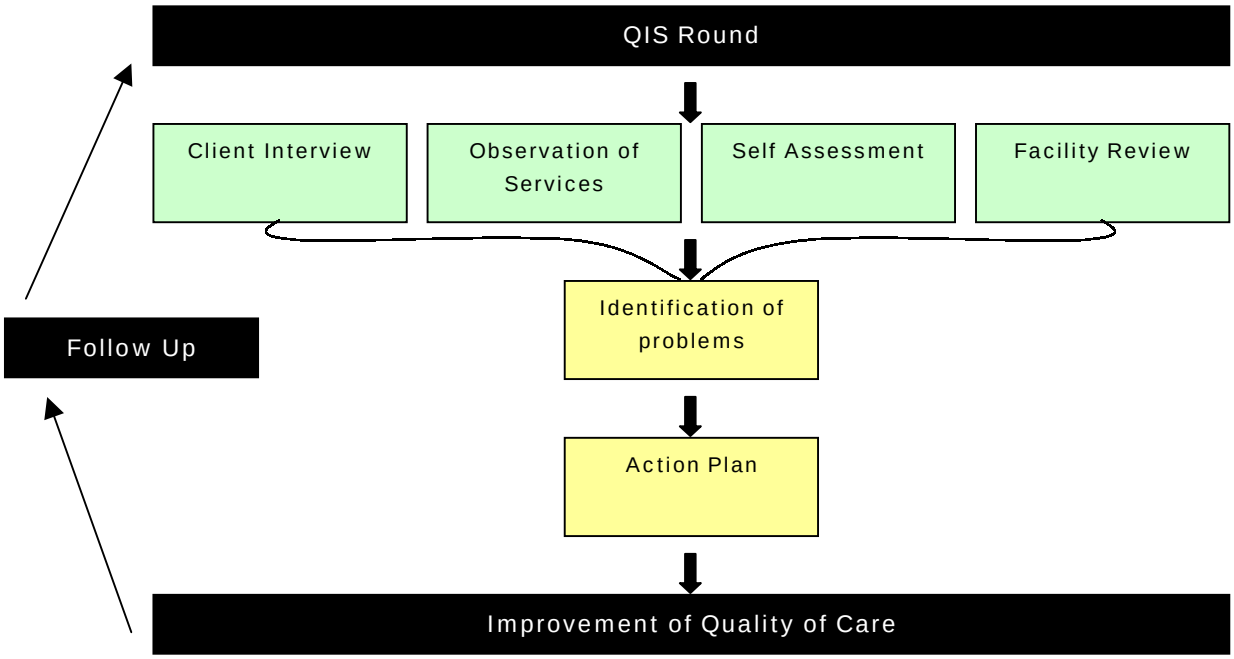
	Objective Measurement of Quality	Subjective Identification of Problems
Clients	Client interviews, closed questions	Facility review Client interview, open questions
Providers	Observation of Services	Self assessment

Once problems are identified using the four tools, the staff of the FGP works as a team to determine the causes of the problems, to identify priority problems and to develop action plans to address priority problems. In the action plans, each problem is assigned to an individual who has primary responsibility for implementing the solution. Three months later, in the next round, the curator returns to review progress

and to repeat the cycle. Unexpectedly, during the pilot project, the curators built such close, trusting relationships with "their" FGPs that they visited far more frequently than once a quarter.

The QIS system aims to continuously measure and improve the quality of care at the facility level by focusing on problems that impair quality but can be solved using locally available resources. It recognizes that staff members are responsible for the quality of care at their own facility and attempts to provide a platform for them to share ideas and work as a team to improve their work and work environment. Figure 1 illustrates how the QIS works.

Figure 1. A QIS Round



VI. Implementation of the QIS

Three rounds of the QIS were conducted at the three pilot FGPs between February and September 2001. The first round took place immediately after the QIS design workshop and the theoretical training of the first curators. In fact, it was the "practicum" for the first workshop conducted by ZdravPlus consultant, Dr. Ton van der Velden.

The system was brand new to Kyrgyzstan and it took time for people to understand it, so the first round went very slowly. It took a while for FGP staff to realize that the QIS was an FGP-driven process, rather than an outside process being implemented by a higher authority. There was also confusion about the role of the NGO conducting the client surveys, "Leader." Some FGP staff thought that "Leader" was in charge of the quality improvement process, while others thought that it had the right to sanction them. Despite these problems, even in the first round, each FGP was able to use all the tools, identify problems and develop an action plan for improvement.

"During the second round, issues of self assessment were more important than in the first round. This shows that the team has more self-criticism, has more desire to improve the work and identify problems."

-- A QIS Curator

The curators conducted the second round without outside assistance. By this time, FGP staff members were familiar with the process and understood its purposes more clearly. Seeing the improvements from the first round inspired them in their attempts to improve quality. By the third round, the FGPs had become even more skilled at the assessment process. They began to take on additional responsibilities and address difficult issues and there were signs that they were taking ownership of the QIS process. One FGP, for example, asked "Leader" to train them to undertake their own qualitative surveys.

The FGPs also began to think seriously about finances. They learned how to find sponsors for clinical improvements and began to think about the sustainability of the QIS system. Two FGPs involved community members in the implementation of actions plan and found local sponsors.

VII. Results

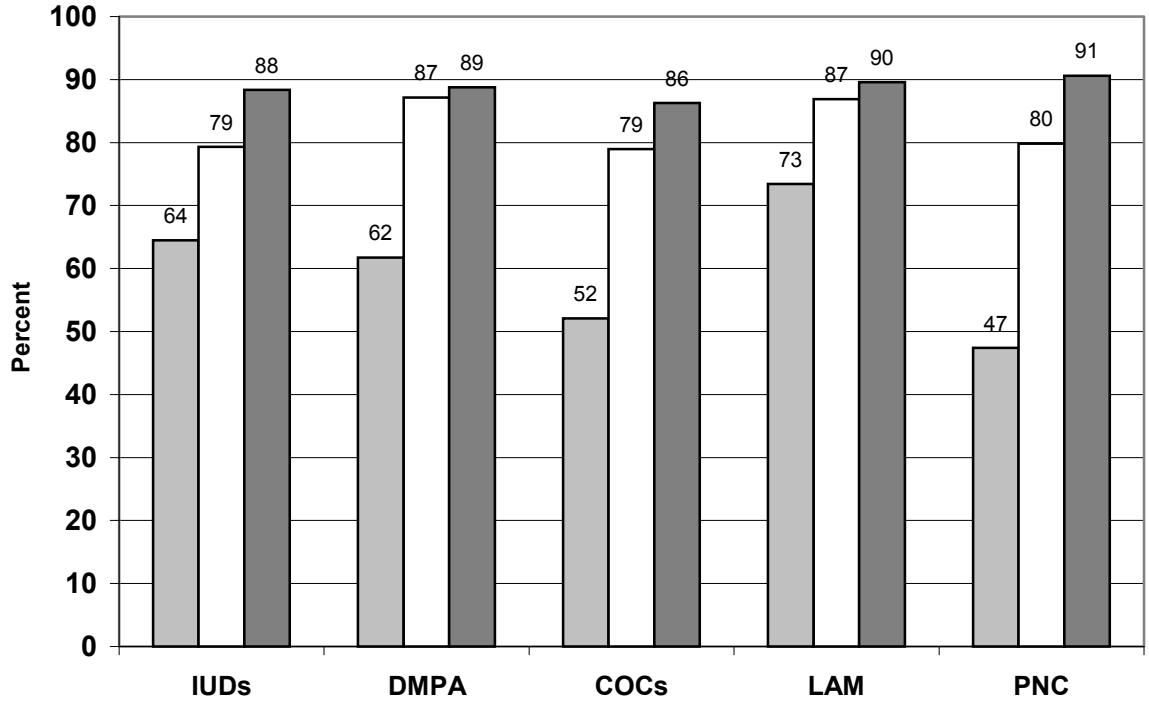
A. Technical Competence of the Providers

In the first round, observation of services revealed an urgent need for improvement. In all three FGPs, physicians were not following national guidelines for the provision of contraception. The average score for all contraceptive services for all sites was just 63 percent. The curators themselves, in their role as FMTC staff, then provided training for physicians and nurses. By the second round, the average score for contraceptive services increased to 83 percent. The third round demonstrated sustained improvement, at 88 percent. See Figure 2 for detailed results.

Observation of services at all three sites also showed that doctors were not following prenatal care standards, with an average score of just 47 percent. After training, the average score increased to 80 percent in the second round and, by the third round, it reached 91 percent.

After the third round of the QIS, the curators determined that the problem of low provider skills in contraception and prenatal care had been adequately addressed and they decided they no longer needed to measure it in each round. Instead, they decided to observe these services only every six months, to ensure that providers' skills remained satisfactory.

Figure 2. Average Scores for Clinical Skills in Reproductive Health, all FGPs, over Three Rounds of QIS (From Checklists Used in Observation of Services)



With RH scores having reached satisfactory levels, the FGPs and their curators planned to broaden the scope of the QIS to include quality improvements in immunization, tuberculosis (TB) care, control of diarrheal disease and management of anemia. The TB program was planning to shift responsibility for the continuation phase of treatment to FGPs, and the pilot sites decided to include the TB cure rate and the percentage of appointments missed in their QIS indicators. Other indicators to be included are the percentage of children who receive the third dose of the DPT (diphtheria, tetanus and pertussis) vaccine before age one, the number of infants treated in the FGP for diarrhea who die, and indicators related to anemia.

B. Choice of Contraceptive Methods

The availability of a range of contraceptive methods – a concern of FGP staff in the self-assessment meetings – was more problematical. Clients in Issyk-Kul have little choice, due to very limited supplies of donated commodities and the high cost of purchasing contraceptives from pharmacies. Clearly, this problem was outside the realm of control of individual FGPs. However, through the link that the curators provided with higher levels of the health system, staff from the FGPs came together to try to resolve the matter. They worked together to ask the Oblast Reproductive Health Center to give responsibility for distribution of donor-provided contraceptives to the FGP Association. And one FGP took an independent initiative, attempting to rent out space to a private pharmacy on condition that it would carry essential drugs, including contraceptives. This issue was still under discussion as the pilot project ended.

C. Information for Clients

All three FGPs improved reproductive health services by making new information on contraception and prenatal care available to clients in their newly-arranged waiting rooms. One FGP supplemented Russian-language materials with information in Kyrgyz, which is easier for most local people to understand. The addition of informational materials in the waiting rooms may have contributed to a 12 percent increase over the three rounds in clients' average scores on a question about whether the client asked questions and got satisfactory answers.

D. Clients' Concerns

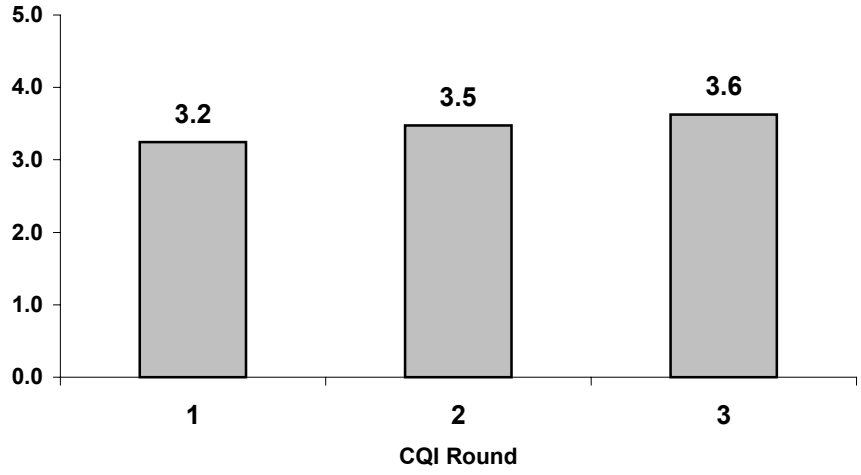
A major shift brought about by the QIS was to introduce healthcare providers to clients' perspectives. Accustomed to a clinical approach to quality of care, the client interviews gave providers unexpected insights into clients' opinions, which were often determined by non-clinical considerations. For instance, a major concern among clients was the FGP facility itself. They listed problems such as a dark and unappealing corridor to wait in, the lack of a cloakroom and cold temperatures. These relatively simple problems had a major impact on their perceptions of quality of care.

The FGPs addressed clients' concerns in a variety of creative ways. One of them borrowed chairs from a maternity house, so clients could sit while waiting their turn, and they reduced cold drafts during Kyrgyzstan's bitter winter by attaching a string to the door to prevent it from blowing open. Two FGPs asked every staff member to bring in a potted plant to make the facility more attractive. All three FGPs improved lighting in the waiting area.

At one facility, when asked about the room where practitioners see patients, clients gave an average score of only 1.6 on a scale of 5. The staff determined that the room wasn't very attractive and thought it provided little privacy, so they created three separate examination rooms, bought flowers, curtains, a painting, soap and towels and, by the second round, clients' scores increased to 2.9 (an increase of 83 percent). By the third round, after further improvements, the score rose to 3.5, a leap of 119 percent over Round 1. Similar efforts increased the score for the waiting room by 23 percent, from 2.3 to 2.8 – though even the round 3 score still leaves much room for improvement.

One FGP, though, was reluctant to embark on facility improvements because it did not own the space it occupied and the staff was concerned about having to move. They devoted time to looking for permanent space.

Figure 3. Clients' Perceptions of Quality of Care, all FGPs, all Rounds



Providers' attitudes were a major issue in clients' perceptions of the quality of care. Often, clients identified providers by name as having a particularly good or bad attitude. They liked providers who were "polite, attentive, tactful, and sensitive," with a "benevolent and respectful attitude." However, interpersonal communication was not addressed in any of the action plans and, not surprisingly, clients' scores remained fairly constant. In the future, interpersonal communications issues merit more attention.

When clients' overall perceptions of the quality of care were measured, there were some quite significant improvements over the three rounds, as can be seen in Figure 3 above.

E. Facility Improvements

Among the most dramatic results of the QIS, was the establishment of laboratory facilities at two FGPs. During the first round, the facility review noted the absence of laboratory facilities at two FGPs. Resolution of this problem clearly would be difficult and the FGPs responded initially with fundraising efforts. They applied for funds from the FGP Association and the Health Insurance Fund and sought community sponsors. After the third round, one FGP had opened a lab, hired a laboratory technician and was doing glucose, hemoglobin and urine tests. It was still in the process of getting more reagents and one of its nurses was being trained as a lab technician. The other FGP had purchased laboratory equipment and arranged for training of a staff member, but had not yet finished rearranging the facility to make space for the new laboratory.

Sanitation was another important concern, both for clients and staff. At one FGP, clients gave the facility a score of 2.8 out of 5 for sanitation. The staff determined that the low score was due to the lack of washstands and towels – hence no facilities for hand washing – a toilet or other sanitary facilities. After finding a sponsor, the staff installed four washstands, provided towels, covers for tables and waste-baskets and they painted the room. By the second round, clients' appreciation increased by 21 percent to 3.4. The staff continued its efforts, with more painting, separate rooms, plants and an information board on sanitation. By the third round, the score had increased to 3.8 (36 percent over round 1) and the staff was still planning to install a toilet – for which they had already identified a private sponsor. While some of the changes were purely cosmetic, the FGP now has facilities for providers to wash their hands between patients, thus impacting on infection prevention.

F. Privacy and Confidentiality

Both the self-assessment meetings and the client interviews identified issues of confidentiality as problem areas. Efforts were made to remedy these problems with simple interventions. One FGP had an examining room with windows at street level and no curtains, so passers-by could easily see in – so they installed curtains. Another FGP placed curtains around the gynecological examining table. All FGPs put locks on the doors and installed signs to indicate when an examination room is occupied, to prevent people simply walking into the room, as often happened. In one FGP, the telephone – which was frequently used – was moved out of an examination room into the reception area. One FGP bought basic equipment for nurses, such as stethoscopes, blood pressure cuffs and stationery, so they would not have to interrupt colleagues and clients in other examination rooms when they needed these items. These efforts raised clients' overall rating of privacy and confidentiality ten percent over the three rounds.

Of course, not all problems were solved. Installing locks on doors to keep people from interrupting consultations was only a stopgap measure. Patients and staff continued to come in – simply knocking on the door until it was opened. The exercise, however, helped providers learn an important lesson – the importance of identifying the underlying causes of a problem, rather than simply jumping to conclusions. They decided to perform a Pareto analysis during the fourth round of the QIS, to identify the root causes of the problem and find out exactly why staff and patients needed to enter the examination rooms so often.

VIII. Lessons Learned

A. About the QIS

At the end of the pilot project, FGP staff and curators considered the QIS a valuable system that they would continue to use. In fact, a fourth round of the QIS took place in early 2002, managed entirely by the FGPs involved.

The QIS is functioning as intended. During the seven-month duration of the pilot, it effectively increased the quality of care and helped the FGPs set priorities for their activities and their funding. Many problems

were solved. Clinical competence in providing contraceptive and prenatal care clearly improved. Client satisfaction increased quite significantly overall and with respect to specific concerns such as sanitary conditions and the waiting rooms. Other problems, such as privacy and confidentiality, were partially solved and remain on the agenda. Other aspects of quality, such as information available for clients and interpersonal communication, received less attention during the first seven months and remain to be tackled.

It is possible that the FGPs managed to resolve the simpler problems with quality of care in the early rounds of the QIS and, over time, will face more complex problems that will be more difficult to resolve. Interpersonal communication may be a case in point. Even so, the QIS has already had important benefits for the management capabilities of the FGPs, which is an important step in a post-Soviet environment where clinic management is a new concept. It is remarkable that all FGPs successfully found sponsors to support improvements and persuaded clients and community members to donate time and skills. The increased client orientation and the experience with fund raising will prove valuable in dealing with more complex problems.

Many long-term problems, however, such as the shortage of contraceptives, lack of permanent premises and funding shortfalls, are beyond the ability of individual FGPs to solve and will continue to hamper the quality of care. It is an important step forward that the FGPs came together to try to resolve some of these issues across FGPs.

The self-assessment meetings proved to be a difficult aspect of the system for the FGPs to master. At the beginning, they had trouble differentiating between a problem and the cause of that problem, as well as with selecting realistic goals. Nurses sometimes hesitated to raise issues in the presence of doctors who might criticize or penalize them. With practice, however, the self-assessment meetings improved, making the FGP action plans both realistic and effective. Better training for FGP staff at the start could have avoided some of these difficulties

Any QIS, however, will quickly reach its limits without additional resources to improve the quality of care. When asked what kind of assistance ZdravPlus could provide to improve their work as curators, one curator replied, "training on management skills, finding sponsors for further progress with the reforms, marketing services, writing grant proposals and receiving grants – because without funds, it is impossible to promote QIS."

B. About the Curators

At the end of the pilot project, the independent NGO, "Leader," conducted focus group discussions with the staff of the three participating FGPs to find out their perceptions of the system. "Leader" learned that FGP staff perceive the curators very differently from the traditional inspectors to which Kyrgyz health providers are so accustomed. Instead, they see them as advocates who can represent them and their needs to higher authorities.

> "…we do not hide the problems from [the curators], but we try to share with them and find solutions".
>
> *-- An FGP staff member*

During the advanced training course that followed the third round of the QIS, the curators summarized their experiences and lessons learned during the pilot project. They made a number of important observations. First, they said it was important that they were physicians, rather than nurses, because it would be difficult for mid-level staff to work as curators with doctors in a facility. Second, they found it helpful to be located close enough to "their" FGP to be able to visit regularly. Third, they observed that their job was made easier because they came from outside the FGP and could see things more objectively. And finally, they emphasized the critical importance of a

confidential relationship between the curator and the FGP because this allowed them to develop a trusting relationship where problems would be raised and openly discussed.

C. About FGPs, their Staff and Communities

In the same focus group discussions, FGP staff reported that the QIS increased their motivation, made them feel part of a team and helped them solve their own problems, without waiting for outside solutions. Thus, one of the most significant results of the QIS was empowering the staff to work in teams and, in the process, building their management skills – a highly significant step for providers who have always worked in a system where they were told what to do and where there was little room for initiative.

The curators noted that the FGPs were more successful when they had a small catchment area and when they owned their own building, so they knew their investments in the facility would not be taken from them by an unanticipated move. The curators agreed that the FGPs needed a motivated clinic head and practice manager, as well as motivated staff, and that they did better when they were allowed to choose their own curator. (Two of the curators changed "their" facilities after the first round, at the request of one of the FGPs.)

FGP staff reported that the QIS increased their motivation, made them feel part of a team and helped them solve their own problems, without waiting for outside solutions.

As already noted, the FGP staff should have been better informed on the design and aims of the QIS right at the start. This would have prevented some initial confusion and would have made the system more effective from the beginning. For example, the tendency to jump to solutions is clearly illustrated by the locks and latches that were installed to prevent people entering examination rooms. Without analysis of the underlying causes, locks and latches did not solve the problem. Additional training on cause analysis would be beneficial.

The system clearly affected how the pilot FGPs were viewed in their communities. For example, an FGP that was not part of the pilot project decided to merge with a pilot site, because they wanted to achieve the same quality improvements.

Government representatives were also pleased. A presentation on the pilot project to the MOH met with outspoken interest and approval. According to Dr. Dzhakypova Roza Seitalievna, head of the Healthcare Delivery and Licensing Department of the MOH, "The system protects FGPs from all unnecessary requirements of numerous 'inspectors' and helps FGPs to prioritize their activities and budget."

IX. Future Plans

With the pilot project over and some generally positive results, other FGPs – in Kyrgyzstan and beyond – want to adopt the QIS. A small cadre of QIS trainers was trained early in 2002, facilitating the expansion of the system in Kyrgyzstan and elsewhere in Central Asia. During the training of trainers, the first round of QIS was conducted in Zhezkazgan in Karaganda Oblast, Kazakhstan. The trainers also expanded the QIS to five additional FGPs in Issyk-Kul who wanted to adopt the system.

"The system protects FGPs from all unnecessary requirements of numerous 'inspectors' and helps FGPs to prioritize their activities and budget."

--Head of the Healthcare Delivery and Licensing Department,

Kyrgyz Ministry of Health

Meanwhile, as already noted, the three pilot FGPs and their curators were broadening the scope of the QIS to address quality improvement in immunization, TB, control of diarrheal disease and anemia. In addition, they plan to work with the local Health Insurance Fund with a view to using the results of the QIS to determine distribution of financial incentives to FGP staff.

The national network of family medicine training centers, under the Kyrgyz State Institute for Continuing Medical Education, is linking the QIS and Continuing Medical Education. Together with the FGP Association, the training centers are helping to expand the QIS to FGPs throughout Kyrgyzstan. Not only will it work as a continuous quality improvement system but it will be used to identify health workers' educational needs from the bottom up – and not only from the top down. Initially, the FMTC in Issyk-Kul will focus on setting up internal QIS processes for FGPs. Then, the ongoing QIS process will help to determine topics for continuing medical education. They also plan on creating a mechanism to analyze routine computerized data from patient visits to FGPs and to feed it back to the FGPs in a form that is both easily understandable to the FGP staff and useful for quality improvement.

For a full description of the results of the pilot project, see: *Ton van der Velden, Results of the QIS pilot in FGPs 3, 10 and 12, January- September 2001, Karakol.*